January 22, 2001
Advisory Committee on Managed Health Care
Discussion Summary

AGENDA ITEM I: Discussion with Business, Transportation and Housing Agency Secretary Maria Contreras-Sweet

DANIEL ZINGALE welcomed everyone, introduced Business, Transportation and Housing Secretary, Maria Contreras-Sweet, and thanked her for her leadership and vision.

ALL MEMBERS introduced themselves.

SECRETARY CONTRERAS-SWEET thanked members for their service; Said the governor is proud of department's work; guiding principles he asked to use for this process are to: (1) Restore and affirm the primacy of the physician in medical decision making; (2) Hold managed care decision makers accountable for their decisions, and; (3) Guarantee consumers have access to a physician's opinion when medically necessary in life threatening situations. The Department will continue to provide full access to all stakeholders and ensure open lines of communication. The Secretary praised the governor for establishing the Office of Patient Advocate and selecting Angela Mora in that position to provide systemic suggestions to the agency on how to improve and work with the department effectively.

DR. JOHN ALKSNE indicated that state has a fragmented system of overseeing health care; Department of Managed Health Care should have a role with uninsured people and coordinate activities with other state agencies.

SECRETARY CONTRERAS-SWEET referred to handouts explaining Department of Managed Health Care's regulatory areas and how they relate to other agencies. Secretary Contreras-Sweet meets regularly with Secretary Grantland Johnson (Secretary of Health and Human Services) to ensure communication and coordination for issues that transcend departments, and Director Zingale works regularly with the Director of Department of Health Services and other persons to ensure the same.

MS. MICHELE MELDEN stated concerns including cultural/linguistic standards, racial disparity on specific diseases, access to care, disabled persons, persons with chronic illness, the need to regulate compliance by plans and regulation in order to deal with these issues.

SECRETARY CONTRERAS-SWEET supported addressing cultural and linguistic issues, medical compliance, issues affecting care for children and disabled, and safety of providers and patients due to injuries.

MR. JOSE GONZALEZ stated his concerns: an underfunded system; consumer displacement or moving with short notice to new providers; contracts which displace people; providers being stressed about their inability to provide care that is mandated, and not funded properly; financial solvency issues including Financial Solvency Standards Board regulations.

SECRETARY CONTRERAS-SWEET: Financial solvency of provider groups affects some safety issues but there are also issues regarding protocols, training, and many other elements to the safety issue. Encouraged group to frame questions appropriately and give them to the Financial Solvency Standards Board. Cautioned about overregulation of private sector and not giving preference to one group over another. The administration is committed to doing everything to see that the private sector succeeds, and at the same time making certain consumers have health coverage.

MR. DANIEL ZINGALE: If committee members ever have something to relay to the Financial Solvency Standards Board, Tom Davies, who is a member of both bodies, may help do so.

MR. PAUL KUMAR praised the department's leadership and catalyzing a dialogue to overcome boundaries to work on organizing an efficient, high quality, responsive system of health care. Incentives in the managed care system aren't subject to appropriate oversight. Safety net providers have a special role. Consumers with complex needs face special challenges in managed care systems. The department can help when there is no legislative remedy in place and when one is necessary to help develop appropriate approaches to those challenges.

SECRETARY CONTRERAS-SWEET said she does not disagree.

DR. JOHN ALKSNE: A big issue is an information sheet; providers are behind in their ability to transmit information about patients. We need patients to have access to information if they're in a different city or they or their providers need information about their conditions and treatment.

SECRETARY CONTRERAS-SWEET: People are sometimes frustrated when asked for the same data in different forms. Hope for economies and efficiencies to manage data. Secretary Contreras-Sweet chairs the governor's Infrastructure Commission, and invited others to share their ideas for improvements.

MR. JAY GELLERT: There are: technology opportunities that we could work together on; a medical error issue (we should accept responsibility and put that issue away); access is an issue particularly as it relates to kids; prevention is an issue (better linguistics, and better cultural sensitivity could be dealt with at a level where there's a much reduced chance of risk).

DR. STEVEN BULL stated his concerns about administrative costs of running plan programs, and making those processes streamlined, and more effective. Specialized plans are smaller, premium dollars are smaller, and in the past the cookie cutter approach applied didn't make sense for some specialized plans.

MR. STEVEN THOMPSON: A legislative proposal is being developed with the California Hospital Association, Kaiser Health Plan and the California Medical Association, based on voluntary reporting system the airline industry uses. The role of the department should be to provide regulatory leadership and oversight. There is a need for the department to restore infrastructure.

MR. LARRY LEVITT: The HMO Help Center has an opportunity to collect information to potentially reform the systems; he has talked with the Director about possibly combining forces on some areas with the Kaiser Family Foundation.

MR. THOMAS PORTER: It's a big challenge to reach consumers, and it's not only going to need creative ideas, but also more resources to reach them with information that will help them make informed decisions.

PUBLIC COMMENT:

- MS. BRIDGET SHEEHAN-WATANBE, Center for Health Care Rights and on behalf of the Managed Care Consumer Advocates Collaborative. Found the department to be both receptive to working with their organizations and responsive to our concerns and requests.

- MS. AMY KAY BOATRIGHT, Center for Public Interest Law at the University of San Diego (speaking on behalf of herself): The issue of access is also related to other individuals. It has been difficult for her as a single law student who's unemployed to get insurance, medical insurance.

- MR. BRETT BARNHARDT, attorney for Kaiser Permanente. There is an essential role for the department as a mediator in trying to grapple with patient safety and solvency and quality issues, the availability and affordability of health care. There is a need to get the stakeholders to communicate and forums need to be structured accordingly.

AGENDA ITEM II: Quality and Performance Measurement Subcommittee

MR. TOM DAVIES: The Quality and Performance Measurement Subcommittee met once to organize itself, and a second time to begin creating a work plan, set priorities and a timeline, clarify expectations of the department, and it heard from two panels: (1) Represented purchasers and consumers (Pacific Business Group on Health, CalPers) and, (2) Represented organizations that have expertise and programs in the area of quality reporting (National Committee on Quality Assurance, and California Health Care Foundation). Herb Schultz explained statutory requirements and the Department’s priorities. The Subcommittee will develop recommendations on a health plan report card, and on a standardized uniform medical quality audit.

DR. BETH MCGLYNN, director of the Center for Research on the quality of health care at RAND presented research on health plan report cards including:

- CARS, a pilot project with federal agencies, including the Agency for Health Care Research and Quality that looked at a variety of ways to produce and present the report card scores with annual data from health plans.

- Steps needed to produce report cards:
  (1) Identify key audiences – everybody who lives in California? The legislature? The health plans? Physicians practicing in California?

(2) Research shows: If information about plans look much the same, then a report card isn't very interesting or helpful to consumers. When choices people make have consequences, a report card can be quite useful. Communicating that the choices people make have consequences is difficult and requires a long-term educational effort.
(3) You have to find out what the audience wants to know. The unit of analysis needs to be meaningful to the audience. Consumers are more interested in what's going on with their own doctor not with the health plans
(4) Information must be accessible to users when they're going to make a decision, for example, during open enrollment.
(5) There should be a framework or organizing device for setting the report up. The way people process information is from general to specific. People can handle 5-7 bits of information when making a decision. No single framework was found to be analytically superior; the reason is there's a limited amount of data to sort into different categories. It is more important to have a framework than the specific framework chosen.
(6) There needs to be standardized methods of data collection and analysis. Data selected should be: (a) available for most plans, (b) reported on for at least one year prior to their use in the report card, (c) continued to be used by plans in the future, and (d) meaningful to the people you're trying to communicate with. Some people think that fewer analysts are better. Consumers generally think more is better. Probably the answer is somewhere in the middle. RAND did not use many utilization measures, financial performance measures, and disenrollment data. Potential data sources included NCQA accreditation, HEDIS, Consumer Assessment of Health Plans Surveys.

- A computer program, “Geo Access,” provides information about the number of primary care physicians per hundred people who live in a geographic area, an attempt to objectify access. RAND looked at (1) using experts; (2) doing some analysis, (3) ask some consumers to do this. RAND felt the combination of expert opinion and analysis was the best approach.

- Questions to address: How to handle missing data, whether or not to standardize the measures that go into the scales, how to weight the individual measures; what confidence interval do we use; how to select cut points, how to determine if one plan is better than another. There is no right answer. RAND identified at least two alternatives for each.

- Data can be missing as a result of plans not collecting it by choice or not having enough data, or other reasons. In some instances, if plans think they can get away with withholding the information, they're going to withhold the information because maybe their performance wasn't good. So the policy question was: Does the approach that we take in handling this new data in producing these report cards affect reaching this goal of complete and accurate reporting?

- Options for dealing with missing data: (1) give no score, or an equivalent indicator, (2) use the average of all measures reported by other plans or the average of with that. RAND standardized scales so measures having a 100-point range count the same as measures that have a 5-point range. RAND weighted measures based on the health benefits and how they affect mortality and morbidity, and how differential weights across measures reflect differential importance to the overall category. RAND used confidence intervals to determine whether the differences between plans are statistically significant.

- There has been little work done on how to transmit this information back to people. There are signs that if people repeatedly get exposed to report cards, then after 3-4 years, they begin to use the information.

- RAND has often found at the market level less variation than nationally, thus RAND went to a 5 star system to try to tease out more discrimination in other markets. Markets tend to either have really good plans or really bad plans.

- There is only anecdotal evidence that report cards affect quality of care. It does seem that the act of public reporting has some relationship to quality and overall performance. What's really absent is management of chronic disease and that's actually the thing that consumers worry the most about. It is important to focus on that.

MR. DANIEL ZINGALE: Stars and letters system seemed a lot more user friendly having done some report cards and imputing zero or imputing the lowest score would probably be his inclination.

DR. BETH MCGLYNN: Many profiling systems look at utilization and related things. They don't really get at quality. It's expensive to collect some useful data given the way data is kept right now in most medical practices. Ideas to overcome these barriers include: using electronic medical records, and having incremental steps as milestone markers to help us get to our long-term goal.

Employers pay most attention to premium prices, not quality or access or other issues. Some pay attention for measures of quality or coverage for specific health conditions that are of interest to their particular employee. In addition, RAND:

- Found no relationship between rates of utilization, how many procedures are done and the appropriateness with which those procedures are performed; it tells nothing about quality.

- Wanted to use disenrollment but it turns out that has problems with the way it is calculated, and we don't know a lot about its nature; it is hard to interpret what it means, and why people are leaving plans and be able to calculate something about disenrollment by disaffected populations, and

- Created the "Perfect Plan," which uses best-observed performance in any measure across the country and constructed a mythical plan that was the best at everything in order to assign scores to the real plans.

MR. JAY GELLERT: Based on the fact that there is not much variation within a geographic area, the committee may want to pick three or four targets to change. It seems where California is low in a high health benefit area, that we should target that reporting and not to change the fundamentals of the whole market.

DR. BETH MCGLYNN: No community always does best and no community always does worst in whatever the metric is that we're looking at. So, it may be important to identify different targets in each community around the state.

A principal way report cards can help make change in a market where there is no choice is by helping people understand what they ought to be getting and helping them become more activated consumers to make sure they get what they need. They are a health education/advocacy tool.

People get more and more satisfied up to a certain point and then, if they're really using a lot of services, it goes back down the other way.

Safety measures are largely not in the report cards because we haven't actually been measuring them, and it's not clear safety is the most effective way to deal with a lot of the safety issues because you run the risk of people not reporting adverse events.

AGENDA ITEM III: Public Comment

No public comment

AGENDA ITEM IV: Regulatory Implementation and Structure Subcommittee

MS. ELIZABETH IMHOLZ: The Regulatory Implementation & Structure Subcommittee met in November and via teleconference in December. It discussed the grievance and Independent Medical Review draft regulations. Key issues identified include:

(1) Definition of grievance;
(2) Interpretation of "resolve";
(3) Notice to consumers when they face an HMO denial; many felt it would be appropriate to also give notice to consumers who were denied on the basis of medical coverage in addition to medical necessity;
(4) Access to Independent Medical Review;
(5) Cultural and linguistic competency issues and access for disabled persons;
(6) External review process accessibility; and
(7) Uniformity and consistency of standards across federal and state agencies.

Secondary issues: (1) Aligning the regulatory language with language from the statute, (e.g. definition of medical necessity; public reporting of both grievances and Independent Medical Review (IMR) decisions).

DR. PRATIBHA PATEL: Minority viewpoints discussed in the Subcommittee include: (1) the broader definition of "grievance;" (2) administrative cost and time could impact patient care, and; (3) the days required for conclusion or resolve of grievances.

MS. JOY HIGA: The Department over summer circulated a draft of the grievance and Independent Medical Review regulations on which the Department received substantial public comment. They were circulated to members of the Regulatory Implementation and Structure Subcommittee, and the Department is reviewing these comments. Once comments are analyzed and presented there are several steps they must go through including going to the Business, Transportation and Housing Agency, several other state departments and the Office of Administrative Law before they become formal proposed regulations.

Dr. Tony Linares and Tom Gilevich are helping set up the Department's process for Independent Medical Review. A contract has been finalized with the Center for Health Care Dispute Resolution (CHDR) to be the primary contractor to the Department that to receive Independent Medical Review cases. There are two other secondary contractors to whom these Independent Medical Review cases will go if CHDR is ruled out because of a conflict of interest. The whole process is set up within our HMO Help Center. So far, no Independent Medical Review cases have come to the Department.

MR. DANIEL ZINGALE: Wants to start with the broader definition and some intelligence about what's out there before the Department starts narrowing it. Because what constitutes a barrier to quality care is, in many ways, in the eye of the beholder. Rather approach that with an open mind. But this is a process for hearing a different point of view in the public hearings and those forums as well.

MS. JOY HIGA: The Department is sensitive to making sure consumers have access to a process that can resolve their complaints and balancing that with the administrative burden that that may effect health plans or providers. Draft regulations have a provision that if a complaint can be resolved by a heath plan within one business day, that exempts it from the same kind of dispute resolution process that would be imposed on a regular complaint. We are making efforts at separating out what can be handled more easily and without the kind of administrative compliance of reporting that other complaints might require.

MR. LARRY LEVITT: Another responsibility of the Subcommittee is to work with the Department to study the feasibility of consolidating regulation of all health insurance, currently under the purvey of the California Department of Insurance into the Department, a legislative requirement of the Committee. This was discussed at length at the first Subcommittee meeting, as was how to define the scope of the study. There was consensus to limit its scope to basically as the legislature defined it: to study feasibility of consolidating the regulation of full service health insurance plans, and plans that provide comprehensive health insurance, and limit the review to entities currently regulated by the Department of Managed Health Care and the California Department of Insurance.

- There was interest in looking at broader issues: regulation of health plans by the Department of Health Services on behalf of Medi-Cal beneficiaries. The Subcommittee agreed after performing the first study to look at broader issues, particularly Medi-Cal issues. The Subcommittee discussed mechanics of the study, what the Subcommittee should look at and how to get it done.

- There was agreement hat it would be appropriate to hire/contract with someone to assist in the preparation of the study and great interest in looking for a California-based academic with knowledge of health care issues, insurance issues and regulatory issues who could get this done in a pretty short timeframe.

- Issues discussed to address as the Subcommittee works through the study: Solvency and its regulation and preservation, establishing a level playing field for regulation of health insurance in California, rules/regulations for consumer protection and quality assurance, conflicting regulatory requirements, the ability to shop for a friendly regulator and avoid an unfriendly regulator as the case may be, how to deal with guaranty funds, or the lack thereof.

- The Subcommittee also talked about the need for intensive fact-finding, and for getting a baseline set of information about how regulation in health insurance/managed care is conducted now in California.

MS. JOY HIGA: Subcommittee members and the public provided the Department with input on a list of academics from around the state to consider for undertaking this study.

MR. HERB SCHULTZ introduced Sean Tracy, Acting Deputy Commissioner for Policy and Research at the California Department of Insurance. Department of Managed Health Care is setting up meetings between Director Zingale, California Department of Insurance Commissioner Low, and our respective staffs to further delve into issues.

MR. SEAN TRACY: The California Department of Insurance has an internal task force on health care. Introduced Marsha Seeley, senior staff counsel, Policy Approval Bureau.

MS. MARSHA SEELEY: The Insurance Code does not define health insurance. It talks about disability insurance, which includes: Disability income, accelerated death benefits, accidental death and dismemberment, credit life and disability, Medicare supplement, long-term care, vision, dental, workers' compensation, hospital indemnity, cancer insurance, specified disease insurance.

The California Department of Insurance also regulates major medical health insurance including individual health insurance, small group, large group; association group and student blanket health insurance. The Code doesn't define major medical. So within each of these health insurance areas are lots of types of products the California Department of Insurance regulates. The Code addresses those lines of products the same as any of the other lines the California Department of Insurance regulates, such as autos, and homeowners. Insurance companies that offer these products come within the Insurance Code in terms of financial requirements and consumer protection and the whole scope of the Insurance Code just as any other insurance companies.

Information about insurance is spread throughout the Code; many deal with substantive issues like mandated benefits, what has to be in a policy, prohibited provisions, what can't be in a policy, minimum levels of coverage, disclosure items. The California Department of Insurance also regulates third party administrators.

MS. PAM GAUME, Associate Insurance Compliance Office at the California Department of Insurance: The Department regulates different lines of insurance, only one is a class of insurance called disability insurance, which includes the list Marsha just went through.

- When it comes to hospitalization, medical and surgical expense policies, comprehensive major medical coverage, the California Department of Insurance only regulates a percent of the marketplace in that line of insurance. But the California Department of Insurance gets a disproportionate number of calls on the hotline and inquiries for complaint resolution because the public perceives us as being the regulatory agency for health insurance.

- Because the rules are essentially the same between both state jurisdictional agencies and the federal agency in terms of Consolidated Omnibus Budget Reconciliation Act (COBRA), the California Department of Insurance resolves a large number of these questions in the agency, even if it isn't under its regulatory jurisdiction. The California Department of Insurance refers calls to the Department of Managed Health Care if and when it becomes an issue that is clearly outside of the Department's jurisdiction.

- In order to serve consumers most efficiently, the California Department of Insurance tries to resolve issues as best possible to educate consumers through our hotline and our Health Triage Team, specially trained hotline officers that deal with more complicated health regulatory issues, continuation of coverage under California-COBRA under the Health Insurance Portability and Accountability Act (HIPAA), now a state regulatory issue, extension of benefits for total disability, and retroactive cancellations.

- It is difficult to give an idea of the volume of complaints the California Department of Insurance gets under "disability insurance" or "health management." While the Department has some statistics relating to formal complaint resolution and written case units or written case complaints within the Claims Service Bureau or the Rating and Underwriting Service Bureau, when it receives hotline calls about a health issue, it can't always define the jurisdictional nature of the issue or even what the problem is in relating to health. Thus, it often becomes coded as general information or health issues or referral out to Department of Managed Health Care. The California Department of Insurance handles a very large number of phone calls; Ms. Gaume can't give a percentage of those calls.

- There is a great potential for consumer confusion for services the California Department of Insurance provides to consumers versus the hotline Department of Managed Health Care runs. Not only are there parallel jurisdictional agencies, there are health plans that have two sides of their operation: Aetna, CIGNA, MaxiCare, Health Net, Humana, PacifiCare offer HMO services, and indemnity companies that the California Department of Insurance regulates and point of service plan products. Where a person has the choice of choosing either an HMO at the point of service when they're sick or to go outside the HMO and get a specialist in the point of service plan. Consumers absolutely do not know where the jurisdictional issue lies.

- Ms. Gaume doesn't know if there is a corresponding code in the Health and Safety Code, but in the Insurance Code there is a section that says if you have a problem with your insurance plan, then call the Department of Insurance, and gives the phone number. Or if you have any questions about your coverage, or on every claim form that comes out, every claim denial that comes out, call the Department of Insurance. These companies that have dual sides on their plans put the California Department of Insurance number on there, and it is not clearly identified, and it is very confusing to the employee as to who they should be calling.

DR. PRATIBHA PATEL: There's nothing in that which regulates any quality of care.

MS. PAM GAUME: No. The complaints the California Department of Insurance handle deal with contract language of the insurance plan, or the issuer of the contract/policy. The Department doesn't regulate quality of care or Preferred Provider Organizations. Preferred Provider Organizations are not regulated. The Department regulates the contract language that allows that benefit plan to use a Preferred Provider Organization or use a network of some sort. As far as Ms. Gaume knows, nobody regulates preferred provider organizations.

DR. STEVEN BULL: Delta Dental is a very large Preferred Provider Organization, and is regulated by the Department of Managed Health Care. It is not a level playing field for plans that carry products that compete with our products, and members of those plans mentioned deserve the same sort of protection in terms of quality of care, access and everything else.

DR. STUART NEEDLEMAN: Do you get a number of calls regarding managed care? And if so, how are the people getting your telephone number?

MS. PAM GAUME: Well, number one, the consumer says, "This is my insurance plan," and they don't distinguish that it is an HMO or Preferred Provider Organization or indemnity plan, and so they assume that it is the California Department of Insurance because that's the insurance plan and the California Department of Insurance is insurance. Some of these plans have dual sides, and because there is a regulation that says that our name and phone number has to be on there for the complaint process and a regulatory agency, that number is on their evidence of coverage/contracts, and so they call us.

Aetna Health Care uses the words "Aetna Health Care" all over their Evidence of Coverage (EOC) documents, regardless of the fact that their plan is actually paid under Aetna Life and Health; so our number is on there. In response to this problem, the California Department of Insurance now hosts the Interagency Health Forum in which includes the Department of Managed Health Care, Department of Insurance, and the Health Care and Financing Administration (HCFA) which gets together on a quarterly basis to iron out these discrepancies between our various jurisdictional agencies to help achieve open communication and consistency of application.

MR. STEVEN THOMPSON: Would it make sense to consolidate the consumer complaint function for both departments?

MR. DANIEL ZINGALE: That's an interesting question. I can put it on the list of things to talk to Mr. Low about when we have the meeting. The Financial Solvency Standards Board has struggled with the issue of public disclosure of financial information. The Department is going to gather more information from HMOs and medical groups about their finances. We've heard providers want to limit that disclosure, so as not to inhibit the reporting of that information or put them at a competitive disadvantage and contractual limitations. And we've heard consumer groups want to release that information and say that it belongs to the public and should be made public. Does the California Department of Insurance have a guidepost that we might look to in terms of the financial information that you all collect, the degree to which you make that public or the criteria you use for what to make public and what to keep in confidence?

MR. HAROLD PHILIPS, a life actuary with the California Department of Insurance, said health lines/products are not provided by health insurers. They're provided by life companies under their accident and health product lines. In California there are “disability” lines; casualty companies can write disability insurance. They apply for that authority, and paternal benefits societies provide most of these benefits. The California Department of Insurance doesn’t regulate health care, as does Department of Managed Health Care. The California Department of Insurance regulates the payment of benefits toward health care – which is what indemnity is.

- The California Department of Insurance looks at certificates of authority in order to offer these products, they need these certificates in California. The California Department of Insurance looks at their financials, and if everything looks okay, we give them a certificate. There are two kinds: (1) domestic companies formed in California under our laws or (2) foreign companies formed in other states, domiciled elsewhere, formed under the laws of other states, which need authority to operate in California.

- Financial reports are required to be filed annually. They are very complete, and require rigorous disclosure of just about everything, and they are available to everybody. In fact, the California Department of Insurance has people there all the time with copy machines, as they are public documents.

- The California Department of Insurance is concerned about the solvency of these insurers, and wants to make sure that they're going to be around for a while to pay the benefits they've promised.

- So with long-term products, you need sufficient reserves, actuary reserves. The Department is very concerned about those. In our audits, the Department looks at all their accounting to make sure the books are honest, all the numbers are proper and also their actuary reserves are in accordance with our statutes, our laws, our regulations and the National Association of Insurance Commissioners’ models.

MR. DANIEL ZINGALE: Is there anything that you keep confidential in terms of financial information from insurers?

MR. HAROLD PHILIPS: The California Department of Insurance considers a few things proprietary: actuarial memoranda that describes product and other information. But all the financial information is entirely public, and it's very, very thorough.

- All health disability products are reviewed carefully, so they meet our requirements. And part of that filing process we have in our Code the requirement that benefits and premiums be reasonable in relation to each other. This is done through a loss ratio. Benefits divided by premiums have to exceed a certain number. For example, in Medicare supplement, they have to exceed a certain percent. The higher the ratio, the better it is for consumers, of course, or that's the assumption.

- The California Department of Insurance reviews all rate increases; companies justify them with their experience, and it reviews their data and approves them, and collects premium taxes – a billion and a half a year and not a penny of it goes to our Department for our budget. We audit the premium tax filing of all the insurers.

- Guaranty funds are included. There are separate ones for health products and for life products. I think California does post-assessments. It varies by state. the California Department of Insurance waits till they go under before assessing carriers.

- Part of our code includes the two guaranty associations. If you offer this type of product, you have to contribute it. It's a percent of premium generally, and there's a maximum.

- An insurance company's annual statement, the major financial report that companies spend most of their time on, has all the detailed information; such as do their assets exceed their liabilities. Within the last ten years, they've used a risk-based capital formula and if their liabilities exceed assets they are considered to be insolvent, and there's many steps you go into, and eventually the California Department of Insurance would take over the company and do whatever has to be done. Regulatory review increases in intensity as you get closer to zero surplus.

- The major purpose of the financial reporting is to ensure that a company is solvent, that it continues to sell, and if it is insolvent, then the California Department of Insurance puts a cease and desist on the company, and it must quit selling. The California Department of Insurance hasn't had one for a few years for the life health side now, not the property and casualty side.

MR. SEAN TRACY: When Commissioner Low took office in October, we reorganized the California Department of Insurance and Enforcement no longer exists. The substitute is that the Investigations Bureau, which was under Enforcement, went into our criminal investigation shop, which is now a combination of fraud and investigations. That's the new branch of criminal investigations. Rate regulation is still there; they approve rate filings as they come into the Department – increases, decreases, changes in the rate structures and those files are reviewed and approve or disapprove those plans. The rate regulation deals with property and casualty lines – it has nothing to do with health.

MR. CHUCK GIBBS, counsel in Department of Managed Health Care, Office of Health Plan Oversight: Under the Knox-Keene Act plans are required to have contracts with providers that regularly deliver services to plan enrollees. That would seem to exclude Preferred Provider Organizations from Knox-Keene regulation, but that's not the case. Two large full service health care service plans that offer Preferred Provider Organization products, Blue Cross and Blue Shield, both also offer HMO products, and have affiliated companies licensed under the California Department of Insurance. There are two other large Preferred Provider Organizations regulated under Knox-Keene, Delta Dental and Vision Service Plan.

- With the exception of Blue Cross, all of the plans with Preferred Provider Organization business were transitioned under Knox-Keene either from the California Department of Insurance or from operation under the Knox-Mill statute. Blue Cross prior to this operated as a nonprofit hospital corporation under the California Department of Insurance. It was brought in under Knox-Keene by a special act of the legislature. It came with its Preferred Provider Organization line of business intact and, its right to continue that line of business was preserved in the legislative action.

- In terms of regulation, Preferred Provider Organizations are regulated the same as HMOs with the exception being that plans offering a Preferred Provider Organization line of business are not required to have contracts with all providers that regularly deliver services. All survey reporting, financial and quality assurance requirements apply to the Preferred Provider Organization lines of business. They are assessed administrative fees for Preferred Provider Organization enrollment as they would be for HMO enrollment.

- With regard to the network of contract providers that are contained in the Preferred Provider Organization product, plans must maintain the full range of health care services through that network, and the services must be available and accessible to Preferred Provider Organization enrollees: the same standard as is applied to HMO plans.

- Under statute, a Knox-Keene plan can assume risk both for in-network and out-of-network services. Plans that seek to operate a point of service product must: (a) be licensed under Knox-Keene for five years; (b) meet certain financial requirements; (c) have adequate working capital and also a record of positive earnings; (d) most important: no more than a certain percent of the total premium revenue can come from the point of service product/no more than half of their business.

- They are regulated the same except that they are not required to have contracting relations with all providers that deliver services. In other words, a plan enrollee can elect to maintain or to seek services within the contracting provider network before going outside.

DR. STEVEN BULL: Well Point, Prudential, CIGNA, Aetna, their Preferred Provider Organizations aren't required to do the same things in terms of quality that our plans are.

MR. CHUCK GIBBS: Many HMOs have affiliates that are licensed under the California Department of Insurance. So, you have the confusion of name recognition.

DR. STEVEN BULL: A company I know has a dental product that is a Preferred Provider Organization and is not regulated by the Department of Managed Health Care. They're under the California Department of Insurance. They do not have requirements for quality, et al, stated earlier. I think there's confusion here, and it's rather a critical point in terms of what this Committee is supposed to be looking at.

MR. CHUCK GIBBS: The key is that licensees under Department of Managed Health Care have affiliated companies that do have a license under the California Department of Insurance. They may be operating under the same name or closely related name.

MR. LARRY LEVITT: Maybe I can clarify: companies operating a Preferred Provider Organization under a Department of Managed Health Care Knox-Keene license is regulated the same as HMOs regulated under Department of Managed Health Care. While the Preferred

Provider Organization plan regulated under the Department of Insurance is subject to different rules than an HMO under Department of Managed Health Care.

MR. CHUCK GIBBS: That's correct. A licensee under the California Department of Insurance would operate under the regulatory scheme of that Department. If a full service plan sought to obtain authorization to offer a Point of Service plan product under Knox-Keene, it would be regulated by the Department of Managed Health Care.

MR. HERB SCHULTZ: Blue Cross operates in the instance of what's regulated by Department of Managed Health Care. It operates Preferred Provider Organizations out of its health care service plan license. Health care service plan is a definition of an HMO within the Knox-Keene Act, which is again regulated by the Department of Managed Health Care.

MS. MARSHA SEELEY: The California Department of Insurance regulates insurance carriers. The California Department of Insurance doesn't have jurisdiction over the contracts it enters into with providers. If a provider network is inadequate, there is nothing the California Department of Insurance can do. The California Department of Insurance doesn't look at those contracts or at provider directories to see if there is coverage in rural areas. The policy would have to be filed, but there could be no enforcement on that particular aspect. I suppose if the provisions of the policy were not being fulfilled, the California Department of Insurance might then from the financial side look to whether or not the company is meeting its obligation and is it performing as it promised and then maybe take some sort of cease and desist action. I don't think this has ever happened.

MS. MICHELE MELDEN: I've run into serving consumers in Preferred Provider Organizations and they expect to get a contracting rate for all the services they need, and when they need a certain service, they can't find a contract provider.

MS. MARSHA SEELEY: The California Department of Insurance hears that complaint often also or that the policy provides for coverage, but in a certain county/city there's not a certain specialist, so they have to travel a great distance. The policy is a contract but the contract with a provider is not a contract with the consumer.

MR. THOMPSON: Unless the contract contradicts the overall contract that the insurance company has with the consumer. Therefore, you may be enforcing a subcontract in order to enforce the larger obligation of the insurance entity.

MS. MARSHA SEELEY: I suppose that's possible. I have to check with our compliance and enforcement areas. I don't think that that has ever happened. The California Department of Insurance needs to make sure that the insurance company is fulfilling its obligations.

DR. STUART NEEDLEMAN: Question, does the insurance company monitor the quality of its care?

MS. MARSHA SEELEY: I don't think that they are required to, and I think that the insurance companies usually like to say, " The California Department of Insurance is not responsible for the quality of care." The Department gets this kind of confusion with consumers a lot who doesn't understand what a company is underwriting or what is included in the contract for their particular coverage. It gets even more confused because you have insurance companies and HMOs that administer self-insured benefits. Their name is plastered over all the paperwork.

DR. PRATIBHA PATEL: I think the issue is should all Californians get health care, the same quality of care, and one department should check on that; they all should be moved toward one regulation in the Department of Managed Health Care or you can go to another department.

MS. MARSHA SEELEY: Well, they're very different products.

AGENDA ITEM V: Public Comment

MS. LISA KOLTUN from Kaiser Permanente worries about administrative costs of Independent Medical Review. If there are overly broad definitions, we will eliminate some individual and small group folks that cannot afford coverage anymore. Also there is concern about coverage and benefits. With the voluntary external review Kaiser has, vendors and agencies we interviewed did not have the expertise nor the desire to get into those issues. Coverage and benefit issues are going to be a bigger and bigger issue for enrollees as the purchasers scale back on benefits. Kaiser needs to be very responsible about what goes out for external review regarding medical necessity. To continue having discussion about patient preference or patient opt-out cases, not a matter of a plan or a physician saying, "This isn't medically necessary," but the enrollee says, "No. I want Dr. X over there at that hospital. It's not part of my network. I want it anyway." Those have to be looked at carefully and not automatically sent out for external review.

Kaiser is seriously considering eliminating a level of review simply to stay within compliance on our time frames with this whole day issue. It's not going to have a positive effect on enrollees. But when a plan is caught between staying in compliance and staying out of enforcement on those issues versus what we can give to that enrollee in that days, I think is really something for serious consideration.

It's hard for people who work in medical centers to get medical records from three and four physicians and specialists, get x-rays, get all of the enrollee's information, get all of the provider information, get all of that in days. Now we cram two levels of review into those days. With external review, it will be three. It's virtually impossible. Enrollees give more and more information with each level of review, which is on the one hand to be expected, but on the other hand they keep adding to the story they're telling, it means we've got to go find more and more information.

Right now members can seek a grievance process through the local medical centers and then if their denial is upheld, they can come to the "regional level." Kaiser is going to consolidate the whole thing into one.

MS. MICHELE MELDEN: Do you analyze whether on the first level you have review of how many people -- the percentage of people that went from that level to the second level?

MS. LISA KOLTUN: A very small number go to the second level. Kaiser is trying to rather than doing two really fast reviews, let's do the most complete and thorough and detailed information that we can. So members will out outside of our system for external review if needed.

MS. ANNE EOWAN from Association of California Life and Health Insurance Companies: The Association is having a forum to bring together both kinds of folks regulated by the Departments of Managed Health Care and Insurance to discuss quality of care, taxation, solvency requirements, and other things and look at what issues we can put together in a side-by-side comparison and what are the obstacles and look what are the possibilities of transferring regulation to this new Department. today.

MR. DANIEL ZINGALE: Would you like to be regulated by us?

MS. ANNE EOWAN: That's exactly why we wanted to have a very reasoned deliberation about what the impacts would be rather than make it an automatic transfer. Their gut feeling is they feel they're okay with the way they are, but that doesn't mean that we're not going to look at how that could work because it's in our own best interest to do that. So we are going to keep an open mind about it and see, where the industry as a whole and working with this group, what it might look like.

MR. HERB SCHULTZ: Are you trying to get your members and nonmembers together in a consensus to hopefully help this process? Do you see one forum, a number of forums?

MS. ANNE EOWAN: I hope by the time that the Regulatory Implementation and Structure Subcommittee decides to discuss this issue that I will have some advice on this and that we as an industry will have a unified position. We can determine how this might look if the transfer of regulation were to occur. If we determined that it just doesn't make sense from a logistical and practical standpoint, I hope to give you good reasons why we feel that way.

Preferred Provider Organizations under the California Department of Insurance have to look at a different tax structure, a different solvency requirement. They pay claims, and have contracts to provide reimbursement for care. They see it as an indemnity product, and a lot of what we want to talk about as an industry is the difference in the way they look at their product. They see themselves as less of a provider of health care as a payor of health services.

The California Department of Insurance does have regulatory authority over health insurance from the standpoint that they administer the codes: utilization review requirements, such as quality of care issues, for example. Insurers have to meet those standards and the Department has to enforce that. Second, opinions and Independent Medical Review are also types of quality care issues. Medical audits and adequacy of network standards are also quality care issues.

AGENDA ITEM VI: Health Care Education and Access Subcommittee

MS. NAOMI STROM, Health Care Education and Access Chairperson: The Subcommittee identified our priorities. First, allocate $2 million for an educational campaign to inform consumers about the Department of Managed Health Care giving consideration to ethnic, language and cultural competency. A major focus of this will be the state of prevention in California. And to that goal, we are working to develop a framework for our report and to include consumer access and preventive services, and future funding for education and access.

The complete budget is being finalized and the part relevant to this will be available at the February meeting of the Subcommittee to be in Sacramento.

Last, a long-term agenda topic will include the important state of prevention in California and will include the scope of issues, consumer groups and what is actually being measured.

DR. ROSETTA HASSAN: The Subcommittee especially discussed looking at access issues, especially for under-served areas, and preventive models for children, young adults and other age groups. The alpha fetoprotein screening program offered to all pregnant women is a good model regarding how they utilize preventive services for birth defects.

DR. STUART NEEDLEMAN: A primary issue was the HMO Help Line and potential educational strategies and messages to promote it, and distribution strategies for educational materials, such as through medical providers.

MS. NAOMI STROM: For a framework that the Subcommittee is developing to define prevention, we're looking to those entities within the state that are doing so successfully as preventive models. The Subcommittee talked with the California Center for Health Improvement, director Karen Bodenhorn and today we have Senior Vice President Patricia Felton.

MS. PATRICIA FELTON: Primary prevention typically tries to prevent disease from occurring and may be achieved by modifying lifestyle risk. Secondary prevention would delay or modify the progression of disease and might attempt to do early detection of a disease through screening. Tertiary prevention would prevent disability and help manage chronic conditions, and could involve rehab programs. Clinical preventive services typically occur in a medical care settings. Community-based preventive services are population-based approaches and can involve whole communities. Social policies for prevention include taxes on alcohol and tobacco.

- Research shows people support prevention. They understand it. They would pay more to receive it. Many are not getting it, a bit under half say they feel that too little is being spent by government on it prevention does cost money. It's a long-term strategy, for the most part. For every dollar spent on prevention education, screening, or other intervention, we can save years of life and reduce costs for treatments. The numbers are different for different illnesses/health conditions.

- Barriers are lack of funding, lack of clinician time, inadequate reimbursement, lack of clinician knowledge and interest, lack of patient involvement and knowledge, lack of office or clinic-based systems that can promote preventive care.

- One model program is that of Washington State that originated in Boston with the Institute for Health Care Improvement with Dr. Donald Burwick. It is working with other practice groups and experimenting with open-access scheduling to assure that patients get seen when they want to be seen and are seen rapidly and other things to foster a patient-provider dialogue, like e-mail, Internet interactions. They have seen a reduction in hospitalization rates, are starting to see increase in revenues, and they attribute that to the fact that they are perceived as providing better quality care.

- AHRQ has funded prevention studies (one at two ways of managing pediatric asthma regarding cost effectiveness), an Internet intervention to educate physicians on how to identify at-risk persons for certain diseases, translation projects (using audio tapes of randomly selected routine visits to primary care doctors and to surgeons.

- A study by Commonwealth Fund of Women's Health looking at why women changed plans found women felt it was the quality of the interaction with the provider that really was a deciding factor for them.

MR. JOSE GONZALEZ asked about education being coordinated with DHS and MRMIB.

MR. HERB SCHULTZ: The Department of Managed Health Care has had discussions with the Department of Health Service and Managed Risk Medical Insurance Board (MRMIB) on a number of subjects, and the Department developed a proposed campaign based on input that we got from the Subcommittee, and from public and private sector folks, and we're trying to have that cleared through administration channels.